

Local Government Annuitants or Continuants Group Health Insurance Application
Instructions for Dual-Choice Enrollment

You may not use this application if you are an active employee or you are an annuitant and your former employer pays your premium.

You must file this application by the end of the Dual-Choice Enrollment period if you want to change to a different health insurance plan or change to family coverage for the following year. If you wish to keep the same plan, but have other changes (for example, adding or dropping a dependent, change of physician only, change of address or name) contact Employee Trust Funds to obtain the appropriate form.

Please read the instructions carefully. To avoid delays it is very important that you complete your application accurately.

1. **Name** – Complete your full name, including your middle name.
2. **Plan Name** - This information is needed so that your current health insurance can be cancelled and your new plan can take effect.
3. **New Group Health Insurance Plan Selected** - In this box write: “Standard Plan” or the name of the alternate plan you have selected.
4. **Other coverage** - Complete this indicating if you or anyone you list on your application is currently insured by another group health insurance policy. **This area must be completed in order to process the application.** If you or anyone you list on your application is enrolled in Medicare, list and provide Medicare effective dates and HIC number.
5. **Persons to be covered** - Make sure you list each person to be covered under the health insurance plan you are selecting and include their Social Security numbers.
6. **Appl. Rel.** - Indicate your listed dependent’s relationship to you (S-Son, D-Daughter, SS-Stepson, SD-Stepdaughter, G-Grandchild, LW-Legal Ward).
7. **Student Status** – Indicate your dependent’s student status, if age 19 or older for 2007 (Y=Yes, has student status, N=No, does not have student status).
8. **Selected Physician** - Indicate the *first and last name and county* of your primary physician. If available, list your physician’s *provider number*. Write **none** if you have chosen the Standard Plan.
9. **Sign and date** - Make sure you sign and date your application.
10. Send your application to:
Employee Trust Funds
P. O. Box 7931
Madison, WI 53707-7931
11. If you are an annuitant, you may FAX your application to (608) 267-4549. The original signed application must be received by ETF.
12. **Your application must be postmarked by the last day of the Dual-Choice Enrollment period (October 27, 2006). LATE APPLICATIONS WILL NOT BE ACCEPTED.**